DOCUMENT RESUME

ED 106 320 TM 004 432

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TITLE The Effect of Evaluative Research on Clinicians' Feelings of Competence, Attitudes Toward Research and Acceptance of a New Approach.
PUB DATE 22 Feb 75
NOTE 8p.; Paper presented at Annual Meeting of the Sociological Research Symposium, (5th, February 22, 1975)

EDRS PRICE MF-$0.76 HC-$1.58 PLUS POSTAGE
DESCRIPTORS Attitude Tests; Behavior; Community Health Services; Evaluation Methods; *Health Personnel; Health Services; Individual Characteristics; *Job Satisfaction; *Mental Health Clinics; Patients (Persons); Prediction; *Program Evaluation; *Psychiatric Services; Self Concept
IDENTIFIERS Staff Attitude Questionnaire

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ED106320
TM004432

THE EFFECT OF EVALUATIVE RESEARCH ON CLINICIANS' FEELINGS OF COMPETENCE, ATTITUDES TOWARD RESEARCH AND ACCEPTANCE OF A NEW APPROACH

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A community psychiatric team intimately involved themselves in evaluative research predicting the significant reduction of dysfunctional client behaviors. Following completion of the study team members responded to a 26 item Staff Attitude Questionnaire (SAQ) determining clinicians' feelings of competence, attitudes about research, and acceptance of the behavioral approach adopted during the project. The responses on the SAQ indicated the team members 1) began to feel competent in coping with and changing client behaviors, 2) expressed favorable attitudes regarding evaluative research and 3) had accepted and adopted the behavioral model in their daily clinical practice after the project was completed. It was concluded that program research which closely involves clinicians in the planning and evaluation stages is likely to lead to changes in clinical practice.

Introduction

Too frequently evaluative research in the psychiatric milieu is pursued without including a method to determine the effect of such research on the clinicians involved in the project (Carstairs, 1967). It can be hypothesized that mental health [illegible] participated in psychiatrist, as well as psychology interns and students, only the full time clinicians had sufficient contact with clients to effect behavior change.

The idea of conducting a study developed as the clinicians shared with each other their sense of feeling "harrassed" by the patients for whom services were being provided. The clinicians felt themselves to be involved too often in crisis intervention (e.g. suicide threats, gestures and attempts; psychiatric hospitalizations). For example, one clinician followed a patient who, in a 6 month period, was hospitalized for psychiatric reasons five times, made 10 suicide threats, 4 suicide gestures, 6 homicide threats, and was placed in a half-way house during crises on 4 separate occasions. Another staff member received "conversational" as opposed to "therapeutic" telephone calls (Brockoff, 1970) from one client every night. Such behaviors elicited extraordinary staff time, energy and anxiety. In an attempt to cope with these behaviors, the clinicians often spent 8-10 overtime hours a week in clinical intervention. Before the study was undertaken the clinicians' feelings of discouragement and incompetence increasingly became the focus of staff meetings and discussion. Perhaps

members responded to a 26 item Staff Attitude Questionnaire (SAQ) determining clinicians' feelings of competence, attitudes about research, and acceptance of the behavioral approach adopted during the project. The responses on the SAQ indicated the team members 1) began to feel competent in coping with and changing client behaviors, 2) expressed favorable attitudes regarding evaluative research and 3) had accepted and adopted the behavioral model in their daily clinical practice after the project was completed. It was concluded that program research which closely involves clinicians in the planning and evaluation stages is likely to lead to changes in clinical practice.

Introduction

Too frequently evaluative research in the psychiatric milieu is pursued without including a method to determine the effect of such research on the clinicians involved in the project (Carstairs, 1967). It can be hypothesized that mental health professionals who have participated in planning and conducting a study are likely (1) to experience feelings of competence, especially if the approach being investigated is demonstrated to be effective, (2) to have positive attitudes toward research, and (3) to accept the approach used in the study. These were some of the expectations influential in determining the research design for an eight and one half month evaluative research project.

Research Problem

A community based psychiatric team, consisting of a clinical psychologist, a vocational rehabilitation counselor, and two mental health therapy aides, participated in the study with a research and program evaluation support unit. While the team also included a part-time

oped as the clinicians shared with each other their sense of feeling "harrassed" by the patients for whom services were being provided. The clinicians felt themselves to be involved too often in crisis intervention (e.g. suicide threats, gestures and attempts; psychiatric hospitalizations). For example, one clinician followed a patient who, in a 6 month period, was hospitalized for psychiatric reasons five times, made 10 suicide threats, 4 suicide gestures, 6 homicide threats, and was placed in a half-way house during crises on 4 separate occasions. Another staff member received "conversational" as opposed to "therapeutic" telephone calls (Brockoff, 1970) from one client every night. Such behaviors elicited extraordinary staff time, energy and anxiety. In an attempt to cope with these behaviors, the clinicians often spent 8-10 overtime hours a week in clinical intervention. Before the study was undertaken the clinicians' feelings of discouragement and incompetence increasingly became the focus of staff meetings and discussion. Perhaps most discouraging was the fact that as the volume and variety of service delivered to patients increased, the psychological problems of the patients appeared to multiply. The clinicians' frustrations due to the apparent ineffectiveness of their clinical interventions led to feelings of incompetence which permeated the psychiatric team's operation.

The New Approach

Eventually, as frustration mounted, the team began to question the approach they employed with patients, an approach which emphasized the psychodynamics of a patient's particular mental disorder. As a result, the clinicians decided to temporarily adopt a different model, one which could be easily learned and applied by each clinician. After investigating

and discussing alternatives the team decided on a behavioral approach to change observable behaviors such as suicide threats and gestures, and attention-getting telephone calls.

Implicit in this approach were the assumptions that (1) mental patients are skilled at social manipulation to attain their own ends (Braginsky, & Braginsky, 1967; Braginsky et. al., 1966; Braginsky et al., 1967 Braginsky et. al., 1968), and that (2) viewing mental disorders as learned behavior may be effective in attempting to change behavior. Having accepted these assumptions the team began to clarify and redefine their interactions with patients. The clinicians became acutely aware of the fact that a comparatively small percentage of their caseload was demanding and receiving a large proportion of staff attention. For example, during the first four weeks of the study, before the new approach was instituted, 84% of the client initiated telephone calls were made by 15% of the clients. Another change which emerged from adopting the new approach was that people receiving services were referred to as "clients", thus de-emphasizing a "sick" patient role. The approach the team decided to use might best be described as a social-learning paradigm (Mischel, 1968; Mischel, 1973), with emphasis on the cognitive factors (Kelly, 1955) in learning and maintaining behavior.

Using the paradigm as a guide the team operationally defined clinical intervention strategies, i.e. "decision-rules", to extinguish dysfunctional (dependency oriented, attention-getting) behavior and to induce client behaviors leading to the development of problem solving skills. The decision rules, and behaviors to which they applied, were defined with such precision that decision

Research Design and Findings

The research design, measuring instruments, data collection and assessment of findings related to client behaviors and attitudes were aspects of the project equally shared by the clinicians and by the research and evaluation unit. The design was essentially a classic experimental model (Goode, & Hatt, 1952) involving collecting data before, during and after the utilization of the new approach. The clinicians charted daily, for four weeks, a variety of client behaviors (e.g. client-initiated telephone calls, telephone complaints from clients' families, suicide threats, gestures and attempts) which were defined as dysfunctional. Following this month of charting (Phase I), the clinicians continued to chart client behaviors and applied decision rules for eighteen consecutive weeks (Phase II). At the end of this experimental phase the team charted behaviors but discontinued the new approach and responded to clients as they had during the first phase (Phase III). At two month intervals, commencing at the beginning of Phase I, each client was asked to complete a Client Service Questionnaire (CSQ) to determine any possible deleterious effects (e.g. increased anxiety, depression, etc.) from the new approach. The questionnaire consisted of 36 true-false items probing how the clients viewed themselves (e.g. whether more depressed), the staff (e.g. whether staff cared about them), and their own behavior (e.g. whether they perceived making fewer phone calls).

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Following this careful delineation of the theoretical and operational approach to be used, the team consulted with their research unit. It was decided to conduct an evaluative study to test the effectiveness of the new approach. The study was designed to demonstrate both an anticipated reduction in dysfunctional behavior as well as an increase in problem solving behavior among the clients being served. The purpose of this article, however, is to document the clinicians' (1) feelings of competence, (2) attitudes toward evaluative research, (3) and acceptance of the model or approach involved in the research design.

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In order to properly understand the effect this study had on staff, it is necessary to succinctly present the principle findings regarding client behavior change. Data analysis indicated that decision rules were effective in significantly reducing dysfunctional behavior operationally defined as (1) after-hour and lengthy telephone calls, (2) family complaints about clients, (3) suicide gestures and threats, (4) psychotherapy no-shows, and (5) psychiatric hospitalizations. Analysis of the CSQ data indicated that the effect of the approach on clients was generally a positive one.

The Effects of Research on Clinicians

When the evaluative research was completed, staff members who participated were given a 26 item Staff Attitude Questionnaire (SAQ) to determine clinicians': (1) feelings of competence due to research, (2) attitudes toward the evaluative project, and (3) acceptance of the behavioral model involved in the research. The questionnaire contained

statements with a Likert response mode (Shaw and Wright, 1967) to indicate strength of agreement or disagreement. On the scale, a score of 1 indicated strong disagreement, and a score of 5 strong agreement, with the content of the statement. Scoring each item for positiveness provided a means to tabulate sums and averages to reflect clinicians' feelings and attitudes.

Eleven statements determined clinicians' "feelings of competence" in coping with client behaviors. The total mean score of 4.05 on these 11 statements, as well as the range of mean scores from 3.25 to 5.00, indicates overall agreement by clinicians with statements suggesting feelings of competence in dealing with clients. Each statement required the clinicians to define what these feelings were following completion of the study. Responses to ten of the eleven statements clearly indicate that the team members discerned a notable positive change in their transactions with clients. All the clinicians reported greater effectiveness in changing the behavior of their clients, and felt they better understood the parameters of such behavior. Table I presents item content and mean scores on 11 SAQ statements representing feelings of competence.

It is important to note that the lowest mean score (3.25) dealt with clinicians' concern about not being telephoned by clients as frequently during the experimental period. This low score was primarily accounted for by the response of one clinician who appeared to be apprehensive about clients calling less frequently.

Nine items on the Staff Attitude Questionnaire focused on staff attitudes toward research. The mean score for clinicians on the seven items was 4.08, indicating a positive attitude toward staff involvement in research. Perhaps the strongest endorsement of research is evidenced by the fact that all clinicians strongly agreed ($\bar{x}$=5.00) that they would recommend research involvement for other

TABLE I: Statements And Means Concerning Clinicians' Feelings of Competence

Item Content	Mean Score
As a result of the study I feel:	
1. effective in changing client behaviors	5.00
2. that clients derived benefits from the project	4.75
3. that I spend more time on "therapeutic" phone calls	4.25
4. less anxious in dealing with clients	4.00
5. able to better define and understand client behavior	4.00
6. that I use therapeutic intervention more consistently	4.00

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4. less anxious in dealing with clients	4.00
5. able to better define and understand client behavior	4.00
6. that I use therapeutic intervention more consistently	4.00
7. that clients' behaviors changed quite permanently	4.00
8. able to better predict client behavior	3.75
9. more knowledgeable about the problems of clients followed by other clinicians	3.75
10. that there was a great reduction of clients' dysfunctional behavior	3.75
11. I was not concerned when clients called less frequently during the experimental phase	3.25

community teams in the agency. Table II shows the item content and mean score for SAQ items focusing on research involvement and responsibilities.

The mean scores for statements concerning research involvement were somewhat higher than those focusing on feelings of competence. The expression of satisfaction concerning research involvement, reflected in the consistently positive scores, prompted a follow-up study to investigate the longitudinal impact of the behavioral approach. Apparently, the demonstrated success of the study had led to strong feelings that research and the instruments (e.g. CSQ) it generated can be effective means of understanding and managing client behavior.

Finally six SAQ items concerned staff acceptance of the behavioral model. The mean score for these items was 4.29, indicating that the staff accepted the new model after its utility had been demonstrated. Responses indicated that the clinicians (1) understood the behavioral model more because of their involvement in the research ($\bar{x}$=4.50), (2) believed the behavioral approach to be more effective than other approaches they had used ($\bar{x}$=4.50), (3) no longer favored the approach used prior to the study ($\bar{x}$=4.50), (4) favored the behavioral model over all others ($\bar{x}$=4.00), (5) intended to use decision rules after the study was completed ($\bar{x}$=4.25), and (6) would not use their previous approach in dealing with clients ($\bar{x}$=4.00).

The Staff Attitude Questionnaire also afforded the four clinicians the opportunity to make individual comments about the research study. The following five statements reflect the content of most of the individual comments: (1) Being forced to think in terms of specific decision rules often prevented rash decisions related to the type of clinical intervention appropriate to a particular client; (2) Using decision rules made the clinicians more aware of the possibility that too many services offered to clients in "crisis" can lead to an expectation that the clients can continue to have an extraordinary amount of staff time -- even if that means "inventing" crises (3) The time saving value of the research enabled the team to develop two new programs, programs which benefited those clients who before had received comparatively little attention; (4) The time saving which resulted from a more efficient use of staff time enabled the clinicians to increase the number of clients to whom service could be offered; (5) The clients seemed to become more independent as a result of the approach and appeared not to rely so heavily on staff in solving problems.

In order to determine the longer range effects of research on clinicians' feelings of competence, attitudes toward research, and acceptance of the behavioral model, the research staff met again with the clinical team four months after the termination of the empirical study. In a two hour probing of clinicians'

TABLE II: Statements And Mean Scores Concerning Clinicians' Attitudes Toward Research

Item Content	Mean Score
1. I would recommend research involvement for other community psychiatric teams	5.00

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Item Content	Mean Score
1. I would recommend research involvement for other community psychiatric teams	5.00
2. I would willingly cooperate with future research projects	4.50
3. Administration of CSQ is worth the effort	4.25
4. Time was not lost to clients due to research	4.00
5. Research did not interfere with services to clients	4.00
6. Collecting the data for the research helped me know weekly the problems of my clients	4.00
7. Project was worth the work involved	3.75
8. Clients were responsive to research questionnaire (CSQ)	3.75
9. I did not dislike asking clients to complete the questionnaire	3.50

attitudes it was revealed that clinicians were still using a number of the decision rules (e.g. discouraging conversational telephone calls) to discourage their clients' dysfunctional behavior. The clinicians continued to feel competent as behavioral engineers, still felt favorably toward the behavioral model, and were so positive about the value of research that they enthusiastically agreed to chart again, for three months, client behaviors.

Conclusions

In summary, although the sample is small there is evidence that to intimately involve clinicians in evaluative research can be effective in increasing (1) their feelings of competence (especially if the empirical study demonstrates effective behavior change), (2) their acceptance of the value of research and program evaluation, and (3) their acceptance of the paradigm implicit in the experimental design. Research in community psychiatry often consists of demographic studies which lead to few if any changes on the part of the clinicians concerned. And when predictive studies are undertaken, seldom are the clinicians involved to the extent which they were in the present study. It would seem that the more energy and time which mental health professionals devote to program evaluation, the more positive they will feel about the research, and the more changes will ensue in their clinical practice.

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